

Human Rights Regulations
Frequently Asked Questions #2
1/10/02

Section of Regulations	Clarification Requested	Clarification Provided
<p style="text-align: center;">Restrictions on freedoms of Everyday life 110 C, 2c</p>	<p><u>Section of the regulation in question:</u></p> <p>C. Exceptions and conditions on the provider’s duties. 2. Providers who use seclusion and restraint may use seclusion and restraint if a qualified involved in providing services to the individual has in advance: c. Documented in the Individual’s service record the specific reason for the restriction.</p> <p><u>Clarification requested:</u> It would be difficult to identify every behavior that may result in a restriction. Our behavioral management programs such as Structured Living Protocol (SLP), Token Reward System and Level Systems are an intrinsic part of our program that has been approved by the LHRC.</p>	<p>The specific reason for the restriction must be documented in the Individual’s service record. This would consist of the reason or reasons known to the provider at the time of the implementation of the restriction.</p> <p>If the Structured Living Protocol does not comply with the requirements in the regulations for the use of time out then a variance will need to be sought to continue with this practice</p> <p>Section 12 VAC-35-115-100 C, 3 and 4 permits the development and enforcement of written rules of conduct that do not conflict with the regulations and are needed to maintain a safe and orderly environment. Rules of Conduct must be approved by the LHRC prior to implementation and when changed. The Token and Level Systems might be considered under the Rules of Conduct provisions.</p>
<p style="text-align: center;">Use of Seclusion, restraint and time out. B., 5a</p>	<p><u>Section of the regulation in question:</u></p> <p>B. The provider’s duties. 5. Providers shall not utilize seclusion or restraint unless justified and carried out according to these regulations. a .The justification of any seclusion and restraint procedure must be documented in the individual’s service plan.</p> <p><u>Clarification requested:</u> Treatment plans are individualized service plans of care, which address specific problems, goals, and actions required to meet or exceed the identified problem. This requirement differs for CMS, which indicated that documentation of the plan to utilize seclusion and/or restraint in the treatment plan would lead to the misinterpretation that a standing order existed.</p>	<p>When seclusion and/or restraint are utilized in an emergency then they would be documented at that time. The justification for the use of seclusion and restraint during the emergency would be documented as part of the order. This does NOT mean that seclusion and/or restraint procedures can be part of a standing order.</p> <p>If seclusion and/or restraint are utilized as part of a behavioral treatment plan it must be approved by the LHRC and documented in the individual’s service plan.</p> <p>Even when seclusion or restraint are included in an individualized service plan (ISP), the regulations require authorization prior to any implementation of the seclusion or restraint. For example, if the ISP specifies that the individual will be restrained each time he attempts to harm another client, it will be necessary to obtain authorization each time the individual attempts to harm another client and is placed in restraint, according to his ISP.</p> <p>If there is a conflict, providers will be held to the highest standard regarding the use of seclusion and restraint that covers their entity.</p>

<p>Use of seclusion, restraint and time out. C., 2a</p>	<p><u>Section of the regulation in question:</u></p> <p>C. Exceptions and conditions on the provider's duties. 2. Providers who use seclusion and restraint may use seclusion and restraint if a qualified individual involved in providing services to the individual has in advance: a. Assessed and documented why alternatives to the proposed use of seclusion and restraint have not been successful in changing the behavior or not attempted, taking into account the individual's medical and mental condition, behavior, preferences, nursing and medication needs and ability to function independently.</p> <p><u>Clarification requested:</u> It would be extremely difficult to assess and document all possible triggers for each resident.</p>	<p>Documentation of the alternatives to seclusion and restraint that the provider has attempted is required. Documentation of something that is unknown to the provider is not required.</p> <p>The behavioral assessment must be completed in accordance with sound, therapeutic treatment.</p> <p>The intent of the assessment is not necessarily to identify all triggers for the behavior but to explain why staff took the actions they did. For example, a very frail individual with diabetes becomes agitated and physically aggressive when his blood sugar levels are out of balance. When he engages in such behavior, he is most frequently the one injured. Staff are reluctant to physically restrain him because his frail condition makes him susceptible to injury. Experience has taught staff that if they place him in a soft, ambulatory restraint as soon as he becomes agitated and immediately contact his physician, the probability of injury to the client is greatly reduced. This is the type of information that should be included in the assessment.</p>
---	---	--

<p>Use of seclusion, restraint and time out. C., 3b</p>	<p><u>Section of the regulation in question:</u></p> <p>C. Exceptions and conditions on the provider's duties. 3. Providers who use seclusion and restraint may use restraint or seclusion in a behavioral treatment plan, but only if the plan has been developed according to policies and procedures. All plans involving the use of restraints for behavioral purposes and all plans involving the use of seclusion shall be reviewed in advance by the LHRC. Such procedures shall ensure that: b. Individual plans are submitted to and approved in advance by an independent review committee, comprised of professionals with training and experience in applied behavioral analysis, which shall assess the technical adequacy of the plan...and the LHRC shall review the plans...</p> <p><u>Clarification requested:</u> Requiring an independent review committee and the LHRC to review and approve every resident's treatment plan would slow the process. The LHRC only meets quarterly. CMS does not permit the use of seclusion and restraint to manage behavior.</p>	<p>These regulations cover providers of many types of services including inpatient hospitals, ICFMR facilities, children's residential treatment centers and community programs. There are different requirements for seclusion, restraint and time out depending on what type of service one provides. Thus, these regulations hold providers to the highest standard (CMS, JACHO, PL 106) that covers them.</p> <p>CMS does permit the use of restraint for behavioral purposes for providers of certain services. Each provider must adhere to the standards that covers its services.</p> <p>This section of the regulations requires the review by the independent committee and LHRC for behavioral treatment plans, which utilize seclusion and restraint. If you do not utilize seclusion and restraint as a behavioral intervention--but rather only in an emergency--then you would not need the approval of those committees.</p>
<p>Use of seclusion, restraint and time out. C., 3b</p>	<p><u>Section of the regulation in question:</u></p> <p>C. Exceptions and conditions on the provider's duties. 3. Providers who use seclusion and restraint may use restraint or seclusion in a behavioral treatment plan, but only if the plan has been developed according to policies and procedures. All plans involving the use of restraints for behavioral purposes and all plans involving the use of seclusion shall be reviewed in advance by the LHRC. Such procedures shall ensure that: b. Individual plans are submitted to and approved in advance by an independent review committee, comprised of professionals with training and experience in applied behavioral analysis, which shall assess the technical adequacy of the plan...and the LHRC shall review the plans...</p> <p><u>Clarification requested:</u> What is the correct composition of professionals for a Behavioral Management Committee?</p>	<p>The regulations indicate that professionals with training and experience in applied behavioral analysis should comprise the committee. The exact composition of the committee is left to the judgment of the provider.</p>

<p>Use of seclusion, restraint and time out. C., 3a, b, c, d, e</p>	<p><u>Section of the regulation in question:</u></p> <p>C. Exceptions and conditions on the provider’s duties. 3. Providers who use seclusion and restraint may use restraint or seclusion in a behavioral treatment plan, but only if the plan has been developed according to policies and procedures. All plans involving the use of restraints for behavioral purposes and all plans involving the use of seclusion shall be reviewed in advance by the LHRC. Such procedures shall ensure that: d. Seclusion and Restraint shall only be included in plans: (1) To address behaviors that present an immediate danger to the individual or others, but only after it has been demonstrated by a detailed and systematic analysis of the behavior itself and the situation in which the behavior occurs...</p> <p><u>Clarification requested:</u> What are the requirements for LHRC approval of specific psychotropic medications for treatment of mental disorders in state MR facilities? Within what period of time must the LHRC act upon the psychiatrist’s recommendation for a specific medication for a psychiatric disorder?</p>	<p>The human rights regulations do not require LHRC approval for psychotropic medications used to treat mental health disorders. However, the regulations do require the LHRC to review and approve behavioral treatment plans that include the use of seclusion or restraint. Medication can be a restraint if its use meets the definitions in the regulations of restraint and pharmacological restraint. See below:</p> <p>“Restraint” means the use of an approved mechanical device, physical intervention or hands -on hold, or pharmacological agent to involuntarily prevent an individual receiving services from moving his body to engage in a behavior that places him or others at risk. The term includes restraints used for behavioral, medical, or protective purposes.</p> <p>5. A “pharmacological restraint” means a drug that is given involuntarily for the emergency control of behavior when it is not a standard treatment for the individual’s medical or psychiatric condition.</p> <p>LHRCs serving state training centers also have been designated as the “specially constituted committee” to meet CMS (formerly HCFA) regulatory requirements. Their duty under CMS regulations is to review and approve the use of all psychotropic medications for residents in state training centers. The CMS regulations do not specify a time frame for the approval. For further guidance on CMS requirements please contact your facility Medicaid expert or review sections 261, 262, 263 and 264 of the Interpretative Guidelines – Intermediate Care Facilities for the Mentally Retarded.</p>
---	--	--

<p>Participating in decision making 70, B, 13</p>	<p><u>Section of the regulation in question:</u></p> <p>B. Providers duties: 13. Providers shall make sure that an individual’s capacity to consent is reviewed at least every six months or as the individual’s condition warrants according to sound therapeutic practice to assess the continued need for a surrogate decision-maker.</p> <p><u>Clarification requested:</u> Is the provider required to address the capacity/LAR issue (every 6 months) for minors-either in the custody of parents of DSS?</p> <p>Does this section mean that the individual whose capacity will never change or the individual who will never have capacity must have their capacity reviewed every 6 months?</p>	<p>This section applies to individuals who need a capacity assessment for the purpose of determining the need for a substitute decision-maker. It would not apply to minors because they would normally, by virtue of their age, have a substitute decision-maker. There are a few circumstances in which a minor may make decisions (see Code section 54.1-2969) and in those situations this section would apply.</p> <p>In those cases when it has been determined that an individual will never have capacity or will never regain capacity, this section would not apply because there would not be a need to determine such capacity.</p>
<p>Restrictions on freedoms of everyday life. 100, A, 1</p>	<p><u>Section of the regulation in question:</u></p> <p>A. From admission until discharge from a service, each individual is entitled to:</p> <ol style="list-style-type: none"> 1. Enjoy all the freedoms of everyday life that are consistent with his need for services, his protection, and the protection of others, that do not interfere with his services or the services of others. These freedoms include the following: <ol style="list-style-type: none"> a. Freedom to move with the service setting... b. Freedom to communicate, associate... c. Freedom to have and spend personal money. d. Freedom to see, hear, or receive TV, radio, books... <p><u>Clarification requested:</u> How do parental rights for minors play into the regulations? If a parent requests restrictions such as access to certain television shows, must such a request go to the LHRC?</p>	<p>As long as the restriction does not impact other individuals and the minor agrees to adhere to it then it would not go to the LHRC. Parent or guardian’s preferences must be considered along with the minor’s preferences according to the participation in decision-making section of the regulations. However, the provider must determine if those preferences are consistent with sound therapeutic treatment or if they conflict with these or other regulations or laws.</p>

<p>Dignity 50, C,7, 8</p>	<p><u>Section of the regulation in question:</u></p> <p>B. In services provided in residential settings, each individual has the right to:</p> <p>7. Communicate privately with any person by mail or telephone...</p> <p>8. Have or refuse visitors.</p> <p><u>Clarification requested:</u></p> <p>Does the legal guardian of a person (specifically a minor) have the right to restrict the visitation/telephone/mail rights of that person?</p>	<p>Guardians must consent to treatment on behalf of the individual. The guardian and the minor have the right to participate in treatment planning and can inform the provider of their preferences regarding visits, mail and telephone. <i>The guardian, the minor and the treatment team may agree on visitation, mail and telephone rules to be included in the treatment plan.</i></p> <p>However, the rights in these regulations belong to the individual receiving services; the provider is required to adhere to the regulations and may not restrict an individual's rights unless permitted to do so by the regulations or unless the provider has received an approved variance.</p>
--------------------------------------	---	---

<p>Definitions 30 “Consent”</p>	<p><u>Section of the regulation in question:</u> “Consent,” means the voluntary and expressed agreement of an individual, or that individual’s legally authorized representative if the individual has one. Informed consent is needed to disclose information that identifies an individual receiving services. Informed consent is also needed before a provider may provide treatment to an individual which poses risk of harm greater than that ordinarily encountered in daily life or during the performance of routine physical or psychological examinations, tests, or treatments, or before an individual participates in human research...</p> <p><u>Clarification requested:</u> Can a provider have a general consent form that lists all components requiring informed consent that are known upon admission? For example, a form that lists physical or psychological exams, lab work and other procedures that all individuals under go upon admission to service?</p>	<p>Yes</p> <p>A provider can develop a consent form that lists these procedures. The provider must provide all the steps required in obtaining informed consent according to Section 12 VAC 35-115-70 Participation in Decision-Making.</p>
---	--	---

**Participating in
decision making
70, A, 5**

Section of the regulation in question:

5. Give or not give written informed consent for electroconvulsive treatment prior to the treatments or series of treatments.

a. Informed consent shall be documented on a form that shall become part of the individual's service record. In addition to containing the elements of informed consent as set forth in the definition of "consent" in 12 VAC 35-115-30, this form shall:

(1) Specify the maximum number of treatments to be administered during the series;

(2) Indicate that the individual has been given the opportunity to view an instructional video presentation about the treatment procedures and their potential side effects;

(3) Be signed by the individual receiving the treatment, or the individual's legally authorized representative, where applicable; and

(4) Be witnessed in writing by a person not involved in the individual's treatment who attests that the individual has been counseled and informed about the treatment procedures and the potential side effects of the procedures.

Clarification requested:

Who does this section apply too? For example, when a provider sends an individual to another facility or state for ECT treatment does this section of the regulations apply?

The regulations apply to providers who are licensed, operated or funded by DMHMRSAS. Therefore, the provider who writes the order for ECT must be licensed, operated or funded by DMHMRSAS to have the regulations apply.

**Participating in
decision making
70, C, 1**

Section of the regulation in question:

C. Exceptions and conditions to the provider's duties.

1. Providers, in an emergency, may initiate, administer, or undertake a proposed treatment without the consent of the individual or the individual's legally authorized representative. All emergency treatment shall be documented in the individual's service record within 24 hours.

a. Providers shall immediately notify the legally authorized representative, as applicable, of the provision of treatment without consent during an emergency.

b. Providers shall continue emergency treatment without consent beyond 24 hours only following a review of the individual's condition and if a new order is issued by a professional who is authorized by law and the provider to order the treatment.

c. Providers shall notify the human rights advocate if emergency treatment without consent continues beyond 24 hours.

d. Providers shall develop and integrate treatment strategies to address and prevent future such emergencies to the extent possible, into the individual's services plan, following the provision of emergency treatment without consent.

2. Providers may provide treatment without consent in accordance with a court order or in accordance with other provisions of law that authorize such treatment including the Health Care Decisions Act (§ 54.1-2981 et seq.). The provisions of these regulations are not intended to be exclusive of other provisions of law but are cumulative (e.g., see § 54.1-2970 of the Code of Virginia).

Clarification requested:

Can providers of children's residential treatment services use medication over the objection of the individual in an emergency?

Yes

This section of the regulations applies to providers of children's residential treatment services.

<p>Confidentiality 80, B, 1</p>	<p><u>Section of the regulation in question:</u></p> <p>C. Provider’s duties.</p> <p>1. Providers shall maintain the confidentiality of any information that identifies the individual receiving services from the provider...</p> <p><u>Clarification requested:</u></p> <p>Some state facilities have emergency vehicles that are identified as that facility’s vehicle. Should the name of the facility be removed from the EMT vehicle when another state law requires that the vehicle be identified?</p>	<p>No</p> <p>EMT vehicles must comply with other state laws regarding the identification of emergency vehicles.</p> <p>Section 122 VAC 35-115-10 C. states:</p> <p>C. Unless another law takes priority, and to the extent that they are not preempted by the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereto, these regulations apply to all individuals who are receiving services from a public or private provider of services operated, licensed or funded by the Department of Mental Health, Mental Retardation and Substance Abuse Services, except those operated by the Department of Corrections</p>
--	--	--

<p>Definitions 30 “Consent”</p>	<p><u>Section of the regulation in question:</u></p> <p>“Consent,” means the voluntary and expressed agreement of an individual, or that individual’s legally authorized representative if the individual has one. Informed consent is needed to disclose information that identifies an individual receiving services. Informed consent is also needed before a provider may provide treatment to an individual which poses risk of harm greater than that ordinarily encountered in daily life or during the performance of routine physical or psychological examinations, tests, or treatments, or before an individual participates in human research. Informed consent is required for surgery, aversive treatment, electroconvulsive treatment, and use of psychoactive medications. Consent to any action for which consent is required under these regulations must be voluntary. To be voluntary, the consent must be given by the individual receiving services, or his legally authorized representative, so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress, or any form of constraint or coercion. To be informed, consent must be based on disclosure and understanding by the individual or legally authorized representative, as applicable, of the following kinds of information:</p> <p><u>Clarification requested:</u></p> <p>CMS requires that a physician must obtain informed consent in psychiatric hospitals. CMS does not required informed consent for psychoactive medications. How can these two conflicting standards be achieved?</p>	<p>The human rights regulations do not require informed consent to be obtained by a physician. Providers who come under CMS standards for psychiatric hospitals might want to consider developing policies that describe the conditions under which informed consent is obtained and by whom to meet the CMS standards. Additionally, these providers may want to include the conditions under which informed consent is obtained and by whom to meet the human rights regulations.</p> <p>For example; Because CMS does not require informed consent for psychoactive medications and the human rights regulations do, a policy could be written that details who will obtain such consent for psychoactive medication.</p>
---	---	--

<p>Restrictions on freedoms of everyday life. 100, A, 1, e</p>	<p><u>Section of the regulation in question:</u></p> <p>A. From admission until discharge from a service, each individual is entitled to:</p> <p>1. Enjoy all the freedoms of everyday life that are consistent with his need for services, his protection, and the protection of others, that do not interfere with his services or the services of others. These freedoms include the following:</p> <p>e. Freedom to keep and use personal clothing and other personal items.</p> <p><u>Clarification requested:</u></p> <p>Can providers develop policies that restrict individuals receiving services and visitors from bringing inappropriate items into the facility? For example: weapons, sharps, personal medications, matches, lighters etc....</p> <p>Can the provider “search” the individual or the visitor for contraband?</p>	<p>The regulations provide several sections that the provider may use to restrict what items are brought into the facility for safety reasons.</p> <p>Section 12 VAC 35-115-100, C, 3 and 4 states:</p> <p>3. Providers may develop and enforce written rules of conduct, but only if the rules do not conflict with these regulations or any individual’s services plan, and the rules are needed to maintain a safe and orderly environment.</p> <p>4. Providers shall, in the development of these rules of conduct:</p> <p>a. Get as many suggestions as possible from all individuals who are expected to obey the rules.</p> <p>b. Apply these rules in the same way to each individual.</p> <p>c. Give the rules to and review them with each individual and his legally authorized representative in a way that the individual can understand them. This includes explaining possible consequences for violating the rules.</p> <p>d. Post the rules in summary form in all areas to which individuals and their families have regular access.</p> <p>e. Submit the rules to the LHRC for review and approval before putting them into effect, before any changes are made to the rules, and upon request of the advocate or LHRC.</p> <p>f. Prohibit individuals from disciplining other individuals, except as part of an organized self-government program conducted according to a written policy approved in advance by the LHRC.</p> <p>Section 12 VAC 35-115-100, B, 2</p> <p>B. The provider’s duties.</p> <p>1. Providers shall encourage each individual’s participation in normal activities and conditions of everyday living and support each individual’s freedoms.</p> <p>2. Providers shall not limit or restrict any individual’s freedom more than is needed to achieve a therapeutic benefit, maintain a safe and orderly environment, or intervene in an emergency.</p> <p>Section 12 VAC 35-115-50, E, 6 states:</p> <p>6. Providers may stop, report or intervene to prevent any criminal act.</p>
--	---	--